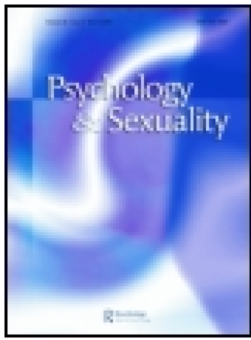

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Optimal Theory case conceptualisation: An African-centred therapeutic approach with Black LGBQ clients

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ABSTRACT

Historic, systemic, and institutional oppression has created various forms of inequality that are of urgent interest to critical psychologists. One area of continued concern is the use of Western, psychological frameworks to address mental health issues for individuals whose experiences lie at diverse intersections of race, gender, and sexuality. This manuscript highlights an alternative framework grounded in an African-centred theoretical approach using optimal psychology. Optimal psychology, also known as Optimal Conceptual Theory (OCT), provides a cultural responsiveness framework for understanding the behaviours, thoughts, feelings, and worldviews of oppressed populations, such as individuals of African descent in the lesbian, gay, bisexual, queer (LGBQ) community. This framework facilitates an affirmative psychological process of examining varying worldviews and their impacts on psychological functioning. By presenting a US-based case study, the authors demonstrate the use of an affirmative psychological framework, OCT, and discuss culturally-affirming interventions, in the clinical setting that also challenge 'WEIRD psychology'.

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Optimal conceptual theory; african-centred therapy; intersectionality; critical therapeutic approaches; critical psychology

Introduction

In the field of psychology, multicultural responsive therapy is increasingly gaining traction (Asnaani & Hofmann, 2012; Gilbert, 2009). This approach is vital due to the continued mental health disparities among racial and ethnic minority populations across the globe (Gallardo et al., 2009). Demonstrated mental health inequities have moved the field towards an emphasis on multicultural competencies, where guidelines are provided for improved psychological practice (American Psychological Association, 2003; Hays, 2009). Although this shift has been important, it is clear that racial and ethnic minorities are disproportionately affected by mental health difficulties in comparison to White individuals (U.S. Department of Health and Human Services, 1999). Those of African descent are particularly affected. Here we use the term 'African descent' as an umbrella term to include African, Asian, Native, White, and non-White Hispanic Americans who have heritage originating from Africa. In the United States (U.S.), African descent populations include people from all over the world, not just sub-Saharan Africa, where most African Americans originate (Agyemang, Bhopal, & Bruijnzeels, 2005; Obasi & Leong, 2009).

Although the need for mental health training focused on multicultural treatment has been well-established, studies continue to indicate that clinicians have better outcomes with White clients (Drinane et al., 2016; Hayes, Owen, & Bieschke, 2015; Imel et al., 2011; Owen et al., 2012). These

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studies highlight the needs of culturally diverse clients who are frequently poorly assessed due to the poor delivery of multiculturally-responsive treatment. Consequently, interventions are frequently ineffective for those from racial and ethnic minorities and other marginalised groups (Alvarez & Kimura, 2001; Constantine, 1997; Delgado-Romero, 2001).

A multicultural responsive treatment framework involves three central tenets. First, a set of core competencies predicts therapy outcomes, which are learned and articulated by mental health trainees. Second, one can reliably differentiate mental health professionals who are culturally responsive from those who are not. Last, mental health professionals use therapeutic characteristics of multicultural responsiveness across their client base (Davis et al., 2018; Sue & Sue, 2008). These therapeutic characteristics include acknowledging differences in the therapeutic space and using language that culturally resonates with the client. One area that requires further examination and evaluation is the use of multicultural *and* intersectional approaches within the therapeutic context (Anders et al., 2020). One such approach is an African-centred approach, a values-based approach that explicitly discusses oppression impacting marginalised communities such as racial and ethnic minorities. In this way, it also echoes activism and praxis that stems from intersectional theory and research (e.g. Cho et al., 2013).

Providing multicultural responsive treatment entails identifying and using the most appropriate clinical approaches when working with racial and ethnic minorities and other marginalised groups. It is essential to help maintain the emotional and psychological well-being of minority clients in order to reduce the mental health disparities among minority populations. In doing so, clinicians can also aid in the ongoing calls for the decolonising psychology as a discipline (Bhatia, 2020) by challenging the historical dominance of 'WIERD psychology' (Western, Educated, Industrial, Rich, and Democratic psychology), and the knowledge derived from it, being applied to all human experiences (Muthukrishna et al., 2020). Mental health issues have substantial costs at the individual, familial, and community level. Many mental health providers who are not practicing from a multicultural framework fail to fully appreciate the process and impacts of marginalisation on mental health. In addition, mental health providers who are not addressing issues of oppression from an intersectional perspective, often apply therapeutic approaches to marginalised populations that ignore or minimise significant/clinically-relevant cultural issues. These impacts include but are not limited to challenges that cut across class, gender, sexuality, race and ethnicity.For LGBQ individuals of African descent, disclosing one's sexual identity means much more than being 'out and proud;' it poses a huge risk. That risk may result in the loss of heterosexual privilege within the African American community, which provides access to support within the community and creates a space to be heard, seen, and validated in the face of racism. The fear of losing this collective therapeutic space within the African American community creates anxiety and, most of all, threatens the affirming community connection of being of African descent. Allowing one's sexual orientation to be revealed, LGBQ individuals of African descent face the potential loss of a significant support system such as their same-race peers and family, in a context where racism is an ongoing issue. LGBQ individuals of African descent who lose their support system within the African American heterosexual community have limited opportunities to develop other communities in which they feel safe and affirmed – a process that can lead to greater isolation and psychological distress (Fukuyama & Ferguson, 2000; Goode-Cross & Good, 2009). For example, in one of the largest studies of LGBQ people of African descent in the U.S., 80% experienced at least one form of discrimination in their lives, 53% experienced racial or ethnic discrimination, and 42% experienced discrimination based on sexual orientation (Battle et al., 2003). These experiences of racial and sexual discrimination are stressors that create isolation and can lead to anxiety, depression, and other psychological difficulties, as a result of minority status.

Minority status stress theory postulates that individuals from stigmatised social categories experience additional stress and adverse life events because of their minority status (Brooks, 1981; Meyer, 1995, 2003). Meyer (1995) proposed three processes by which LGBQ people experience minority stress. First are the stressful life events that occur as a result of one's minority status, common in

homophobic cultures and other environmental stressors. Second are the anticipation that such overtly stressful events will occur and the resulting hypervigilance. For example, an LGBQ individual of African descent may expect rejection or more serious recriminations because of their sexual minority status, so they hide their sexual identity as protection from physical or psychological harm. Third, and most personal, is the internalisation of negative attitudes and prejudices from socio-cultural the context. For LGBQ people of African descent, the epitome of this third process is internalised homophobia (Meyer, 1995), which affects the process of accepting one's sexual identity. This process has the most potential to be damaging because it can create a very fraught context of self-directed disdain and have adverse effects on one's ability to cope with external stress as well as other health issues (Quinn et al., 2015).

Compared to heterosexual individuals, the LGBQ community is at increased risk of mental health issues such as major depressive disorder, generalised anxiety disorder, and panic disorder (e.g. Cochran & Mays, 2009). Minority stress theory posits that LGBQ individuals of African descent are additionally disadvantaged due to disproportionate exposure to social disadvantages, including the stress of discrimination from heterosexual individuals, sexual orientation concealment or hiding part of their identity, and fears of being excluded from their Black community (Myers, 2003).

Researchers suggest the root of the higher prevalence of mental health issues among LGBQ people is linked to the stigma, prejudice, and discrimination they face on a daily basis within a heteronormative world (Friedman, 1999). And while White LGBQ individuals are likely to seek therapeutic services (Balsam et al., 2005), there is a lack of research documenting the experiences of LGBQ individuals of African descent seeking help. According to Conerly (2001), the essential question faced by LGBQ individuals of African descent is how to find a space in which their sexual orientation and racial identity can safely be disclosed and coexist. Sexual identity development is complicated for LGBQ individuals of African descent due to their race, culture, and exclusion from the White LGBQ community (Martinez & Sullivan, 1998). To address this need and gap, a call has been made for an intersectional framework that uses African-centred psychology and therapeutic approaches with Black LGBQ individuals in order to address the unique intersections of minority status stress they experience.

Previous scholars have asserted that the needs of LGBQ clients warrant attention with cultural practices (Israel & Selvidge, 2003; Kocarek & Pelling, 2003; Pope, 1995). Optimal conceptual theory is a theoretical approach that promotes and facilitates the development of an African-centred world-view. It examines systems of oppression and historical events that have disenfranchised people of colour and proposes that various forms of psychopathology are a result of such subjugation and the imposition of a suboptimal worldview. Intersecting forms of oppression often causes Black LGBQ clients to internalise racism and homophobia and, in turn, endorse suboptimal values.

LGBQ clients of African descent are often marginalised by racism in mainstream LGBQ culture as well as by heterosexism and homophobia in their ethnic communities (Balsam et al., 2011; Rosario, Rotheram-Borus, & Reid, 1996). Thus, this community is at risk for isolation, estrangement, and increased psychological vulnerability. Internalisation of oppression can result in identity confusion and self-hatred of one's identity (Martinez & Sullivan, 1998). As a result, ethnically diverse LGBQ people may present in counselling with various mental health concerns such as depression and anxiety (Garofalo et al., 1998). To address this marginalised population, we present a clinical case study, *Akeem*, and demonstrate the process and usefulness of Optimal Conceptual Theory.

In this paper, we use a case conceptualisation, based on the therapeutic work of the first author, to demonstrate how culturally responsive mental health providers can enhance the therapeutic relationship and improve clinical outcomes. Specifically, we recommend this approach when working with clients who have coexisting marginalised identities that lie at the intersection of race, gender, and sexuality.

African-Centered Framework

The emergence of African psychology in modern times occurred during the sociopolitical racial struggles of the 1960s within the U.S. (Turner, 2002). However, historically, it can be traced back to ancient Egypt in which Africans produced an organised system of knowledge and systematic approach to understanding persons of African descent, designed to describe personalities, attitudes, emotions, and behaviours (Belgrave & Allison, 2006). This system of knowledge is based on an African cosmology and corresponds to African conceptions of the social universe. It is the science of exploring the lives of people of African descent from a perspective that is centred on their lived experiences (Belgrave & Allison, 2006).

African psychology is consistent with indigenous psychology movements (e.g. Burton, 2013; Smith, 1999) that offers new norms for the behaviour and human experience of clients of African descent apart from those provided by the dominant culture. African psychology rests on the premise that traditional psychotherapy approaches are ineffective for clients of African descent. These approaches include treatment interventions that are incompatible with the cultural practices and belief systems of such clients (Nobles, 1991). African-centred approaches offer the potential to reach underserved populations and make treatment more accessible and compatible to those who might otherwise reject it.

African-centred psychology, consisting of African-centred theories and therapies, is a culture-centred philosophy that is developing in many directions. Although there are unifying principles and values that are considered African-centred, there is no one definition of what it means to be African-centred and no agreed-upon African-centred theory or treatment approach. The term African-centred is a broad concept used among African-centred scholars, and there are multiple African-centred therapeutic practices within African philosophy and the African-centred framework. There is variation among African-centred scholars on how they define African-centred; there is no existing criterion that has been operationalised.

One approach is Optimal Conceptual Theory, developed by Linda James Myers (1988), which describes an African-centred worldview as an alternative, universal worldview that is centred in Africa as the historical point of generation. Myers suggests that an African-centred worldview can be described as optimal if one places value on peace, harmony, balance, and positive interpersonal relationships. From this perspective, African knowledge is based on the ideas that reality is both spiritual and material; interpersonal relationships are valued; and self-knowledge is the foundation for all knowledge (Myers, 1988).

Optimal Conceptual Theory

Optimal Conceptual theory (OCT), grounded in African philosophy, posits that a 'suboptimal' conceptual system currently dominates our worldview – a way of thinking that is oppressive, leading to both mental or/or physical unwellness (Myers, 1988). According to Myers, the sub-optimal system is fragmented and perpetuates oppression in various forms. The suboptimal conceptual system is grounded in Eurocentric ideologies; focuses on the ego, individualised personality, and outward appearances; and alienates individuals from a connection to the self. Conversely, the optimal conceptual system is grounded in African-centred ideologies based on self-knowledge, explorations of interrelationships, and the interdependence of forces of consciousness reflected in all phases of life (Myers, 1999). Myers suggests that as human consciousness evolves, there is greater understanding and insight into the nature of interrelatedness and interdependence of all things within the world (such as other people, nature, and spirituality), leading to less fragmentation and fewer contradictions. OCT enables us to offer better therapeutic responses to the complex difficulties clients encounter. In addition, OCT addresses the urgency of connecting the positive intuition of the unconscious and the knowledge of the conscious. It provides an opportunity to explore the development of the wisdom of human systems at

individual and collective levels. It also offers a framework of values that provides direction and boundaries for future development of mental health and well-being (Myers, 1999). The goal of OCT is to harness African-centred values and knowledge in order to enhance human well-being and relational capacities.

OCT provides a cultural lens and framework for understanding the behaviours, thoughts, feelings, and worldviews of oppressed populations. It encourages us to confront such worldviews, acknowledge how they negatively impact psychological functioning and foster mental health distress – due to the harms created by systems of oppression. The theory allows for more integrated and successful responses to the complex difficulties marginalised people encounter. In addition, OCT offers a framework of values that provides direction and boundaries for future development of mental health and well-being (Myers, 1999).

Belief Systems Analysis

To facilitate movement from a suboptimal worldview to a more optimal one, Myers (1988) developed Belief Systems Analysis (BSA), a therapeutic approach derived from OCT. BSA is an African-centred cognitive therapy in which the client's current worldview or belief system is explored and then contrasted against an African-centred belief system. BSA is a holistic approach that posits the search for self-knowledge and understanding as a primary human force. To do this, increased knowledge, wisdom, and understanding of self and others is promoted (Myers, 1999). According to Myers, an optimal worldview gives primacy to values such as peace, harmony, balance, compassion, truth, justice, and reciprocity, thereby reducing the degree of focus on the external and superficial.

BSA is a treatment approach that seeks to explicitly instil values consistent with African culture, such as collectivism, interdependence, capacity for transformation, and spirituality – values that have aided African ancestors to survive periods of enslavement in the US. African-centred interventions seek to revitalise traditional African and African American cultural values in people of African descent who have had their cultural heritage erased or suppressed through processes such as enslavement, displacement, acculturation, or other oppressive practices.

BSA attempts to explore and understand the history of oppression that people of African descent have experienced and its impact on their current health and wellness. This approach examines intergenerational trauma, for example, the enslavement of people of African descent within the US context (Watts-Jones, 2002). This includes, but is not limited to, experiences of physical and mental harm, and displaced in various countries across the global, while stripped of all African traditions, language, cultures, beliefs, and values previously practiced. BSA's holistic nature attends to early experiences and socialisation, thoughts and feelings, behaviours to foster self-awareness, understanding, and acceptance, all of which are aspects of psychodynamic, cognitive-behavioural, and humanistic-existential models, respectively (Speight et al., 1991).

BSA requires the transformation of consciousness for both the client and the clinician. To understand and effectively implement this approach as a clinician, it is essential not only to experience the optimal conceptual system but also to live by it (Myers, 1988). Myers (1988) identifies a range of prerequisites before engaging in this type of work: first, a belief in the conceptual system; second, the ability to engage in the client's belief system and the ability to point out the benefits of change; third, the ability to continue to evolve with the client; fourth, an understanding that the client and therapist share a familiar context; and last, awareness of the difficulties and challenges inherent in making the transition from one conceptual system to another. BSA emphasises and promotes African-centred values and principles including spiritual development, intrinsic self-worth, extended self-identity, di-unital logic, self-knowledge, and a holistic worldview. These principles comprise the optimal conceptual system that Myers defines.

Principles of Optimal Conceptual Theory

Principles of Optimal Conceptual Theory first and foremost promote spiritual development which seeks to enhance functional understanding of a creative force that is omnipresent in daily life. Such a force is a measure of the quality of one's relationships and connections to an ultimate, vitalising spirituality. Spiritual development is not limited to religion or a specific religious practice, although that may be the case for some people. Intrinsic self-worth is another African-centred principle instilled in BSA. Intrinsic self-worth describes the understanding that one's value is inherent and divine, rather than dependent on external circumstances or achievements. Extended self-identity speaks to the collective nature of African-centred theory and philosophy and the way individuals see and view themselves in connection with others (including their family, community, ancestors, nature, and so on). The principle of self-knowledge entails a process of critically analysing all the information about a person's life and determining one's 'truth' based on revelations and personal experiences.

Di-unital logic is a specific way of thinking and reasoning that is optimal and consistent with an African-centred worldview. Di-unital logic is a transcendent system of reasoning. It is the union of opposites, a balance between bad and good. Di-unital logic considers 'both/and' rather than 'either/or'. These African-centred principles comprise the optimal conceptual system and worldview promoted by Optimal Theory/BSA. They are used in therapy as a guide for understanding client's presenting concerns and as interventions in an attempt to educate, promote, model, and facilitate adherence to the optimal conceptual system. The optimal conceptual system, also known as an African-centred worldview, is a protective against psychological distress (Neblett et al., 2010). The suboptimal/optimal continuum is used to help the clients see how their conceptual systems dictate the nature and quality of their experiences (Myers, 1999).

Case Introduction

To protect the confidentiality of the client, in what follows, we have provided pseudonyms where appropriate and altered or removed identifiable information (such as the client's occupation). Akeem is a single, 29-year-old, African American man, and lives independently in a midsize urban city in the Midwest of the US. He is a self-referred client to a community mental health agency. He presented to therapy due to feelings of anxiety, work-related stress, relational stress, fixation on professional relationships, and withdrawn behaviours in social settings. Also, Akeem was seeking services to 'figure out who I am'. He described having felt distressed since childhood, inadequate around his peers, and alienated because he was 'different'. He constantly sought approval from adults, and now he seeks approval from colleagues.

Akeem reported that he is the younger of two biological siblings and has two half-siblings from his father with whom he reports having limited relationships and social interactions. His parents separated when he was in elementary school, and he reports having two different types of relationships with them. He described his relationship with his father as a 'working relationship' over practical matters such as bonding when he got into to car troubles; fixing broken household items; and advice about work related situations, such as how to ask for a raise. Akeem further described their relationship as 'not close, I never really know what to say to him'. Akeem describes his mother as a 'friend' or 'friend-like'. He stated that he is 'able to talk to her about anything, and that she is more like a friend who is good and bad'.

Interpersonally, Akeem reported that his friendships are all physically distant and that he does not have close local friends. His long-distance friendships are all 'surface-level conversations', not emotionally intimate, and contact is infrequent (every couple of months). When the therapist further explored what he means by this, Akeem stated feeling like he is the odd one out in social settings and that he has to make more of an effort to spend time with friends including initiating contact. Akeem reported that

he feels like he is continually bothering his friends. He reported that his friends are all of African descent and heterosexual. He stated that he often worries how they will perceive him.

Educationally, Akeem holds a Master's degree in education from a large flagship university on the east coast of the U.S. Akeem reported that during the process of obtaining his graduate degree, he felt like he was not pursuing his passion of music because he was afraid of his parents' reactions and of potentially not making enough money to live a comfortable life. Professionally, Akeem worked at a local, predominately Black high school as a 'college prep' counsellor, helping students obtain scholarship money through college preparation courses.

Akeem reported no medical issues, but he was prescribed medication (Ativan) for anxiety by his primary care physician. He reported some improvements of his anxiety symptoms – a reduction in overthinking when in social situations and persistent concerns about future interactions – but he continued to feel anxious most of the time. In terms of mental health treatment history, Akeem reported previously seeing three therapists, who all were White men or women. Akeem reported that he felt like he did not connect to his previous therapists but continued to go because he felt like he 'had to'. Akeem later reported that his previous therapists were 'missing pieces of his identity of being Black and gay'.

Spiritually, Akeem identified as Christian and active in the church choir, attending services almost every Sunday. Akeem reported that the being in the choir and having a chance to be connected musically kept him socially connected to others in the African American community, but that he feels judged for his sexuality. Akeem stated that he would sit towards the back of the church to reduce these feelings.

Akeem reported a history of sexual abuse as a child by care providers, their partners, and by an old college friend. Akeem disclosed the abuse to his mother at age eight and again at age nine, when he experienced an emotional breakdown. He reported that his mother responded inappropriately and minimised the situation and his feelings. He stated that she did not follow up with any action against the perpetrators. Clinically, Akeem met the diagnostic criteria for an anxiety disorder with a subthreshold of post-traumatic stress disorder. He did not meet all of the criteria for PTSD although he described symptoms that are consistent with post-trauma.

At the time of the initial assessment, Akeem presented as quiet and reserved. He made limited eye contact. His thoughts were linear and clear. During the first session, he omitted his sexual orientation. When given a mental status exam, Akeem was oriented and positively functioning. He did not express or endorse perceptual disturbances, suicidal ideation or thoughts of harming others. He stated that he was constantly worrying about 'offending people' whom he meets (hypervigilance) and often feels that people are 'talking about him' (paranoia). Akeem reported concerns about 'being man enough' and whether he matches up to the societal norms of Black masculinity. Shortly, in a later session, Akeem stated that he is sexually attracted to both men and women (not using the term 'bisexual') and did not consider himself gay. He rejected the term 'gay' due to the negative associations it may conjure, such as being 'less of a man' compared to heterosexual men. As the therapist and Akeem continued to explore these thoughts and feelings around sexuality, it became clear that Akeem identified as gay and was not attracted to women.

In therapy, Akeem was open, motivated, and ready to work with the therapist. He was an active participant, open to the therapeutic process, worked readily on therapeutic homework, and discussed his past challenges. Akeem and the therapist collaborated and agreed with the recommendation of weekly individual therapy to reduce his anxiety symptoms and to improve overall functioning. With Akeem's history of working with White therapists using Western theoretical approaches, he expressed openness, motivation, and was eager to begin working with a male African-centred therapist through active participation and the process of discussing past trauma. Regarding prognosis, Akeem's presenting concerns were consistent with individual therapy and was shown to be responsive to treatment.

Conceptualisation

Optimal Conceptual Theory was used to provide a culturally specific conceptualisation of Akeem's presenting concerns. Conceptually, Akeem's distress is a result of internalised oppression and a suboptimal worldview. Internalised oppression is the process of buying into messages of inferiority and superiority that are anti-self and driven by societal values and beliefs. Internalised oppression presents clinically as hopelessness, isolation, self-doubt, negative self-view, depression, anxiety, and other forms of psychological distress. Internalising messages of inferiority due to being a Black gay man that Akeem has been socialised to believe about himself from society, his community, friends, and loved ones created intense feelings of anxiety and depression and confusion about his identity. Akeem's experiences of oppression, specifically racism and heterosexism are root causes of his distress. Helping Akeem connect his experiences with oppression, including the intersectionality of multiple identities, will serve as a protective factor in resisting internalising self-defeating messages in the future. This is a critical component of the therapeutic process. Additionally, Akeem presented with a worldview and beliefs that are suboptimal. Specifically, his description of his experiences and thoughts and feelings connected to these experiences were rooted in dichotomous thinking (either/or thinking), extrinsic self-worth (valuing other's views, values, and opinions), individualism (disconnected from others and self), and a fragmented worldview (focusing only on negative outcomes and factors). Understanding how these values and beliefs are suboptimal and creates distress and maladaptive coping is another critical component of therapy. Further, introducing Akeem to a worldview and value system that is optimal (African-centred) and allowing him space and opportunity to process his experiences through this framework is another important focus of therapy.

Belief Systems Analysis was the therapeutic approach used guiding the therapeutic process. BSA is a *spirit-led* approach, meaning that there is no set agenda at each session and no set number of sessions or an available treatment manual. Instead, it is 'client-centred–' tailored to meet the specific needs of the client. There are three phases of therapy that the client undergoes within the OCT/BSA framework. The first phase of therapy is cognitive-based in which the therapist examines the client's worldview. The therapist explores and process the client's beliefs, values, and worldview. During the first phase of therapy, the client's presenting concerns are conceptualised using the OCT framework. Specifically, the therapist gets an idea of how various forms of oppression are impacting, contributing to and/or maintaining the client's distress. Additionally, information about the client's worldview and racial identity is revealed through questions that explore these concepts in depth. Cognitive restructuring and challenging self-defeating thoughts and views are critical components of the first phase of therapy. Also, during phase one of therapy, an assessment of the BSA principles (spiritual development, holistic worldview, di-unital logic, extended self-identity, intrinsic self-worth, and self-knowledge) are thoroughly explored which becomes a point of intervention and education during phase two.

The second phase of therapy is psychoeducational and focuses on introducing the client on an African-centred worldview (the optimal conceptual system), as described by Myers (1988). During this phase of therapy, the client learns the difference between a suboptimal and optimal worldview, including the benefits and protective nature of adhering to a worldview that is culturally congruent to the client's background. Additionally, psychoeducation about the client's cultural background and history is provided to increase awareness regarding the impact of various forms of oppression, generational trauma, and patterns of behaving that stems from systemic structures and historical injuries. During the second phase of therapy, the client is introduced to an African-centred worldview and value system in which he or she can experience the value of an alternative belief system and decide for themselves how much change is needed, if any. The main goals of phase two are raising the level of consciousness of the client and gaining a deeper understanding of the self. According to Myers (1988), self-knowledge and

a higher level of consciousness, which contextualises historical injuries and oppression as catalysts of psychological distress, are essential to the healing process.

The third phase of BSA therapy is supportive and less didactic. During this phase of therapy, the client is able to discuss their challenges and distress from the context of oppression and a suboptimal worldview that begins to provide relief and liberation. During the third phase of therapy, the client demonstrates a high level of consciousness, a strong sense of self, and an understanding of how oppression is internalised and manifests in maladaptive ways.

Therapy

During the first phase of therapy with Akeem, the therapist began to explore and examine his belief systems, worldview and racial identity. Prior to engaging in therapy, Akeem completed a variety of assessments measuring symptoms, worldview, and his racial identity. These assessments provided some insight into where Akeem identified in terms of his worldview and racial identity and guided the examination process of the first phase of therapy. Additionally, during the first phase, the therapist explained to Akeem his theoretical orientation and therapeutic approach, and the difference between Western clinical practices and an African-centred practice. The therapist provided information about a value-based therapy, the principles of Optimal Conceptual Theory, and the purpose of teaching the client the OCT language. The therapist explained that the treatment is an African-centred modality and promotes egalitarianism between the client and the therapist, a mutual 'participant and participant' relationship wherein both parties feed off each other and move through the treatment plan and towards an optimal worldview.

After the therapist and Akeem reached a comprehensive understanding of Akeem's worldview, beliefs, and identity, they moved into phase two of therapy. During this phase, the therapist helped Akeem process his view of self through psychoeducation about intersectionality. Specifically, psychoeducation was used to facilitate discussion about Akeem's racial, gender, and sexual identities and the socialisation associated with each category. This process involved identifying and discussing the oppression experienced by gay men of African descent in the U.S. This intervention allowed Akeem to process his thoughts and feelings on issues related to himself being a gay man of African descent. Akeem engaged in open discussion about criminal injustices, ideas of masculinity, men of African descent and friendships, and the perception of gay men of African descent in his career. The OCT/BSA framework provided a safe and sacred space for Akeem to engage in dialogue that is relevant to his daily experience. Akeem acknowledged that he has not been able to experience this level of dialogue, self-reflection, or understanding in other therapeutic settings, due to the lack of consideration or discussion related to the various forms of oppression that impacted (his) psychological distress.

Throughout phase two of therapy, Akeem discussed recent events and news about the challenges faced by men of African descent such as the killing of Black men via police brutality. In addition, the therapist provided space for Akeem to identify and process barriers to psychosocial well-being and discuss topics related to his life as a Black man. Akeem openly shared his weekly experiences, while the therapist also shared with Akeem the similarities he experiences during his week, acknowledging the commonalities they shared. This level of sharing demonstrated the importance and value of an extended self-identity which is antithetical to individualism. Additionally, the self-disclosure of the therapist served to strengthen the therapeutic relationship as well as allow both the therapist and Akeem to gain a deeper understanding of themselves simultaneously. Myers (1988) discusses the importance of the therapist openly sharing and disclosing experiences that are similar and relatable to the client as a way to highlight the collective experience, energy, and wisdom that is necessary in the healing process. As noted above, Myers suggest referring to the therapist-client dyad as

participant-participant to reduce or eliminate the power differential, making the energy and space safe for sharing.

Additionally, during phase two of therapy, the therapist further explored Akeem's identities by using bibliotherapy, encouraging him to read books written by Black gay men that parallel his life, and researching notable figures in African American history. Along with bibliotherapy, the therapist used himself as a tool of rapport building. As a Black man, the therapist used some reciprocal self-disclosure and expressed his thoughts and feelings on his experiences as a man of African descent in the U.S.

In addition to discussions about racial and gender socialisation, bibliotherapy, and the acknowledgement of similar experiences, the therapist used writing as a tool to process Akeem's emotions and to create a 'safe space' where Akeem can write his feelings without real or perceived judgement. These writing prompts included letters to his father, letters to his current self, and letters to his future self, describing his experiences of being a Black gay man. In addition to describing his experiences, these letters were self-affirming. They included dreams and positive beliefs about himself and about being African descent. Akeem was also able to identify and express the significance and value of intrinsic self-worth, self-knowledge, and the principle of extended self-identity (especially in connection with others – including their family, community, ancestors, and nature).

Outcomes of Treatment

The therapeutic relationship described above lasted for one year. The duration was determined by Akeem articulating a decrease in symptoms and deeper understanding of an African-centred approach, and discontinued medication for anxiety. Akeem's distress was identified a result of internalised oppression. Akeem internalised the overt and covert messages that he would often hear, see, and experience directly from society including loved ones. Engaging in OCT/BSA provided an opportunity for Akeem to gain insight into how experiences of oppression contributed and maintained his distress. He was able to externalise his experiences by contextualising the root cause of the oppression that lead to his distress. OCT/BSA had a positive impact on Akeem. His worldview, beliefs, values, racial identity, sexual identity, and overall view of self and view of self in connection with others cultivated a stronger sense of self that Akeem described as affirming and liberating.

Conclusion

This case study provides support for the necessity and significance of an African-centred framework, specifically Optimal Conceptual Theory (see also, Mpofu, 2011). OCT is beneficial in increasing an individual's African-centred worldview, which, in turn, can lead to positive clinical outcomes including a decrease in anxiety and depressive symptoms. Identifying and addressing knowledge and history of being a part of the Black LGBQ community and processing and acknowledging the oppression of race and sexuality served as an important pillar to OCT for anxiety symptoms with a Black, gay-identified client. As demonstrated in Akeem's case, an African-centred framework conceptualisation can provide the client with a deeper connection to their cultural identity and an African-centred awareness that increased positive self-worth and investing in the therapeutic alliance.

An African-centred framework approach such as OCT is relevant to clients of African descent globally who are a part of the LGBQ population, and should be considered as a tool for enhancing the clinical conceptualisation and intervention techniques of OCT/BSA. These findings support African-centred worldview studies that document links between African-centred worldviews and psychological health. Such work also fits within a larger movement to decentre WEIRD psychology as dominating psychological theory and clinical practice. Most fundamentally, our work calls for culturally responsive therapy that addresses intersections of race, gender, and sexuality. It also highlights the continued need for such approaches to be part of the psychological curriculum in higher education. In addition, we have also demonstrated that the gender and racial 'matching' were integral to OCT/BSA and the

success of the therapy. Hence, in order to meet the growing needs of racially, sexually and gender diverse clients, the pool of psychological/clinical trainees continues to require more accelerated diversification. This means designing and implementing graduate training that not only goes beyond WEIRD psychology, and is not hostile to gender, sexual and racial/ethnic minorities, but involved diverse instructors and is committed to decolonising psychology as a discipline.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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